Mrs Kim Crosskey

Pearson Park Care Home

Inspection report

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Date of inspection visit:
31 March 2022

Date of publication:
17 June 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Pearson Park Care Home is a residential care home providing personal care to 19 people, some of whom may be living with dementia and mental health needs. The service can support up to 24 people. It accommodates people in one adapted building and bedrooms are both single and double occupancy.

People's experience of using this service and what we found
There continued to be a lack of oversight and systems in place to drive forward improvements since the last inspection. Similar concerns were identified in relation to maintenance, infection prevent and control, staffing, risk management and good governance systems.

Infection control practices were not robust and placed people and staff at risk of spread of infection. The environment and equipment used within the service required maintenance and health and safety systems were either not in place or effective at reducing the risk.

Staff continued to receive an inadequate induction, training and / or supervision to ensure they had the support, appropriate skills and knowledge to care for people. Some people did not receive their medicines as prescribed.

People were supported by kind and caring staff, who did not have enough time to meet their needs. There was not enough staff in place. The lack of staffing had affected people's ability to access the local community and meant staff were task focused in the way they provided care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Recruitment checks were in place to ensure the right people were employed.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 1 September 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations and continues to be rated inadequate.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service remains inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pearson Park Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing, assessing risk, infection prevention and control, health and safety, premises and equipment, staff training and support and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service remains 'Inadequate' and the service is therefore still in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Pearson Park Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors attended the inspection.

Service and service type
Pearson Park Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the provider, deputy manager and a care worker.

We reviewed a range of records. This included seven people's care records (some in part only) and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We asked for assurances regarding risks we identified during the inspection. We continued to seek further information from the provider to support the inspection. We spoke with three relatives of people using the service and two care workers via telephone.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- People continued to be placed at risk through a failure to adequately address health and safety concerns in the building. Risks in relation to window safety, radiators and the stairs had not been assessed with appropriate actions taken to mitigate potential risks. The provider took some action after our inspection to put systems in place to address these risks.
- People were exposed to a risk of harm as checks in relation to legionella and fire safety had not taken place. We identified fire doors which did not close properly and one door which had a hole all the way through. This would not protect people in the event of a fire.
- People's health needs were not clearly documented, and associated risks were not always considered. This was identified at the last inspection.

The failure to assess and monitor risk was a continued breach of Regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to deploy enough staff to meet the needs of the people they care for and support. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- There was not enough staff to meet people's care needs or to ensure the cleanliness of the building. The building was not clean, and care was task focused. For example, staff did not have time to spend with people outside of planned tasks such as personal care or eating and drinking
- The provider could not be assured there was enough staff to meet people's needs. The tool the provider used to assess the staffing levels was not completed accurately. The layout of the building and people who required a higher level of support or regular checks had not been considered on this tool.

● We observed people waiting for support including drinks, meals and personal care.

Failure to have enough staff was a continued breach of Regulation 18, (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment checks were in place to ensure only suitable persons were employed at the service.

Preventing and controlling infection
● We were not assured that the provider was accessing testing for people using the service and staff. Systems in place to monitor and have oversight of staff testing in line with the guidance, were not adhered to.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. The service was unclean.
● We were not assured that the provider's infection prevention and control policy was up to date. The policy and systems in place to ensure adherence to the policy were not embedded in ways of working.
● We were somewhat assured that the provider was meeting shielding and social distancing rules. Some risk assessments were in place; however, we did not observe people being encouraged to social distance.
● We were somewhat assured that the provider was admitting people safely to the service. Systems were in place, however, the provider lacked knowledge of guidance in relation to isolation.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Staff had received training but systems in place to assess competence were not clear.

The provider had failed to ensure effective IPC measures were in place. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was using PPE effectively and safely.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
The provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely
● People did not always receive their medicines as prescribed. Directions for administering medicines before or with food were not always followed. This could affect the effectiveness of the medicine being administered.
● Staff who supported people with their medicines were appropriately trained. However, clear systems in place for ongoing checks of their competency to administer medicines were not in place. Following the inspection, the provider provided evidence of regular checks in place for two staff members.

Failure to have systems in place for the safe administration of medicines was a breach of Regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Safeguarding concerns were recorded and shared with the appropriate authorities.
● Accident and incidents were recorded, and the provider evidenced appropriate follow-up actions had

been taken.

- Learning from safeguarding concerns or accident and incidents was not consistently applied

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to ensure staff had received suitable training to meet the needs of the people they care for and support. This was a further breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

- Staff were not supported in their role in line with the providers own policies. Staff had not received supervisions or appraisals as stipulated in the provider's policy.
- The providers training matrix demonstrated staff were not trained or did not have up to date training, in areas to meet people's needs such as dementia, epilepsy and stoma care. This presented a risk that people's needs would not be met.
- The systems in place to assess staff competency was ineffective and exposed people to the risk of poor practice. For example, a large number of staff had not had their competency checked for their moving and handling techniques, to ensure this was in line with current best practice.

The failure to ensure staff received sufficient support, supervision and training was a continued breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
At our last inspection the premises were not properly maintained and had not been adapted to meet the needs of people using the service. This was a further breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

- The building and environment was not well maintained. Areas of the service required maintenance including walls, carpets and flooring. Radiators were rusty and windows mouldy and/or had paint flaking. Decoration was needed throughout the building.
- Equipment in place including commodes, shower chairs, chairs and pressure cushions required replacing.

● The environment had not been adapted to meet people's needs, including for people who were living with dementia, for example, the use of signage and colour contrast.

The failure to ensure the service and equipment were maintained was a continued breach of Regulation 15, (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet: Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People's lunch time experience was impacted by a lack of staff. There was a delay in food being served and some people had finished their meal when other people had just received it. One person being supported to eat their meal, was interrupted on numerous occasions as staff were needed to support with other areas.

● People did not always receive drinks when they wanted. Regular drinks rounds were in place, but staff could not accommodate additional drinks requests due to a lack of time available.

● People were not consistently provided with a nutritious meal. People continued to be served four sachets of cuppa soups, boiled in a large pan for all residents as an evening meal. Although some alternatives were now available, the quality of the food provided had not improved since the last inspection.

● The service worked with health professionals when required.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law
At our last inspection systems were either not in place or robust enough to ensure people' received person-centred care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● Information gathered through assessments carried out prior to people being admitted to the service was used to create a plan of care. This was not always in the detail required to provide person-centred care.

● The provider lacked knowledge and understanding regarding best practice. We signposted the provider to best practice guidance to develop their approach.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection systems were not robust enough to ensure best interest decisions had been made in line with MCA. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● Records showed that decisions had been made in line with the principles of the MCA. We identified one situation were a capacity assessment and DoLS application was prompted by an external professional and not the service.
● Where DoLS applications had been made, the provider had systems in place to monitor these.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as inadequate. At this inspection this key question is now requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity
At our last inspection the provider had failed to protect people from degrading care. This was a further breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● Care staff demonstrated a caring attitude towards the people they supported. However, they could not ensure people were well respected due to the failings within the service.
● People's dignity was not respected. People lived in a dirty environment and in bedrooms which had stained carpets, smelt and were poorly decorated. People were provided with worn bedding and towels.
● People's independence was not always promoted. Staff were task focused and did not have time to support people with their independence. People who accessed the community independently were encouraged to do so.
● People's records were stored securely, and access was observed to be limited to staff who required the information to carry out their roles.
● Staff knew people and their needs well. We observed some kind and positive interactions between staff and people. One person told us, "They are good to you in here." A relative told us, "The staff really care about [Name]."
● We saw some examples were staff respected people's diversity and treated them as individuals.

Supporting people to express their views and be involved in making decisions about their care
● Staff were observed seeking permission from people and giving people a choice about where they wanted to sit.
● Relatives were involved in people's care reviews. A relative told us, "Every year they have a review and the social worker, and the manager would ring me. Before the pandemic we would be invited to the service and we would discuss things. We were always involved in that."
● People were enabled to make day to day choices for themselves such as where to spend their time in the house, what clothes to wear and what drinks they would prefer. However, the range of options for how people spent their time was limited.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People continued to express a wish to access the local community more frequently. Three people told inspectors they wanted to visit the local park. One person said, "I want to go out more - get more fresh air, but there aren't enough carers." The provider told us, "People haven't been out into the local community for two to three months, due to staffing issues."
- A basic programme of activities was in place. During the inspection we observed some people enjoying karaoke in the lounge.
- Relatives were kept informed during the pandemic about any change in care needs or how visiting could be arranged. A relative told us, "Communication has been good up to now. Anything I want to know; they ring me, or I will ring them."
- Care plans did not always contain information about how to provide people with personalised care. This included how to meet people's specific health needs and activities they would like to be involved with.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- We identified one person who spoke limited English. Although the provider said they often translated for this person, this was not reflected within their care plan.

End of life care and support

- People had been offered the opportunity to discuss their end of life care wishes if they wanted to.

Improving care quality in response to complaints or concerns

- There were no complaints recorded since 2019.
- Relatives we spoke with did not have any complaints to make but knew who to raise concerns with.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At our last inspection systems were either not in place or not robust enough to ensure compliance with regulations. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider had failed to ensure the service made the necessary improvements following the last inspection and having been placed in special measures.
- There continued to be a failure to manage risks posed to the health, welfare and safety of people. This included IPC, fire safety, window safety and risk management.
- There continued to be a lack of oversight of the premises and the equipment to ensure it was safe and clean.
- The action plan in place to address maintenance concerns raised during the inspection was of poor quality. The plan lacked specific details and dates to ensure improvements were made in a timely manner.
- Audits had failed to identify the concerns we found during the inspection.
- The oversight of staffing levels was poor. Systems in place were not accurate and additional resources, such as agency staff, had not been employed to improve the staffing provision within the home. This was despite the provider acknowledging a lack of staffing meant people had not been able to access the local community for two to three months. The provider told us staffing levels were affected by staff sickness and difficulties in recruiting new staff.
- The provider had failed to take necessary action to ensure people were receiving safe care in line with regulations and did not fulfil assurances given to CQC following the last inspection.

Failure to assess, monitor and improve the quality and safety of the service was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
- The provider demonstrated an understanding of the duty of candour.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- People did not receive person-centred care focused on outcomes. The service needed much improvement to ensure people were empowered to achieve good outcomes.
- The service demonstrated they worked with external professionals when required.